group policies and procedures

# death of service user policy

|  |  |
| --- | --- |
| Category | Clinical |
| Author | Castleman Healthcare Ltd |
| Responsible Director | Dr Dominic Hennessy |
| Date of issue | February 2017 |
| Next review date | September 2025 |
| Document ref & version | Death of Service User Policy V1 |

**Related policies and guidance**

**Document revision and approval history**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Version | Date | Author | Approved by | Comments |
| V1 | Feb 2017 |  |  | Reviewed by DH - references, edits updated |
|  | Aug 2019 |  |  | Reviewed unchanged JL |
|  | Sep 2021 |  |  | Reviewed unchanged DH |
|  | Sep 2023 |  |  | Reviewed DH |

# Document Summary

The way Castleman Healthcare Ltd staff manage and report the death of a service user is set out in this policy and procedure.

The effective management of the death of a service user, its reporting and any subsequent enquiry is of primary importance and can help all those involved gain resolution and come to terms with the death in a safe way as well as creating learning opportunities for service improvement and patient safety.

This policy has been developed to provide a systematic approach to maintaining compliance with all guidance in this area.

# Introduction

All healthcare providersregistered with the Care Quality Commission (CQC) are required (under the [Health and Social Care Act 2008](http://www.legislation.gov.uk/ukpga/2008/14/contents)) to notify the CQC of a number of incidents, events, and changes.

This includes notifications of the death of a patient.

Providers do not need to notify CQC about every death of a registered patient, however, they must provide details if the death occurred while care was actually being provided, for example:

* While a patient was in consultation with their healthcare professional.
* While at the health centre or surgery where the care is being provided.
* During a home visit.

In addition, providers must notify us of deaths that occur within two weeks of a clinical interaction with healthcare staff if:

* the death was, or may have been, as a result of the care or how it was provided, **and**
* could not be attributed to the course which the illness or medical condition would naturally have taken if the deceased had been receiving appropriate care and treatment.

You would not, for example, need to notify the CQC of the death of a cancer patient that had an appointment for pain relieving medication the previous week.

These notifications must be submitted without delay and the reporting requirements shall be as per the following procedure:

# Procedure

The healthcare provider whether directly employed by Castleman Healthcare Ltd, or subcontracted to them shall immediately complete the CQC Death of a Service User form available from <https://www.cqc.org.uk/guidance-providers/notifications/death-person-using-service-notification-form> and shall immediately raise a Significant Event Reporting Form.

The healthcare professional should send the Significant Event Form and Death of a Service User Notification Form to the Castleman Healthcare Ltd. Administrator who will immediately contact the Governance Director who will begin investigations and offer support to the healthcare professional(s) affected.

The Governance Director shall review the Significant Event Form and the Death of a Service User Notification Form and instruct the administrator to send the latter to the CQC via its portal. Any communication from CQC regarding this incident shall be monitored by the Administrator and passed back to the Governance Director who shall instigate any actions as required regarding changes to service delivery, patient safety, learning, review of policies and protocol etc.

Meanwhile, a full investigation shall be undertaken by the Governance Director with regards to the Significant Event.

If the death is being formally investigated by the police, coroner, Health and Safety execute, local authority etc. the Governance Director shall liaise with each authority as required, putting any recommendations in place and/or aiding with investigations, with the input of the healthcare professional who raised the event.

The Governance Director shall also determine whether this event is notifiable under the Duty of Candour (Regulation 20 of the Regulated Activities, Regulations 2014) and if required inform the relevant persons of this death.

The Governance Director shall be responsible for instigating a Significant Event feedback meeting, to fully discuss the death and to put in to place any learning, training, or change to services/policies to ensure all those who were involved in the incident get feedback at the earliest opportunity and that the service is fully reviewed to ensure its safety for all patients.